Annex 5. Health Relief and Recovery Fund to respond to the health crisis in Lebanon and four strategic investments in health

1. Concept note and rationale

Relief and response, recovery and reform

A. The effect of the crises compounds systemic distortions

Lebanon is in the midst of one of the most severe and complex crises in its recent history. Until mid-2020, the health system managed to cope. It then crashed, the collateral damage of a perfect storm of political deadlock, fiscal crisis, economic meltdown, social instability and collapsing infrastructure. The conjunction of crises amplified the effects of pre-crisis distortions and paradoxes: decades of near-universal access to sophisticated tertiary care in the presence of underfunded preventive, promotive and primary care; people struggling to purchase branded drugs or vaccines in the private market, while they are available for free in the primary health care network of the Ministry of Public Health; and supply-induced demand with unsustainable and unrealistic expectations. Widespread poverty, deteriorating living conditions and dwindling access to care now threaten the health and efficiency gains of the previous years.

B. Relief and response

In today's environment of acute crises, there is an urgent need for an immediate response to unmet and escalating health needs. Relief needs to focus on access to essential ambulatory and hospital care for a population that can no longer afford health care, in a context where many providers face insolvency, and where the public purchasers of care face ominous financial constraints. Given the urgency and the current disarray of public funding of health care, the immediate relief and response efforts may to some extent have to be formatted as targeted, time-limited project funding focused on access to care. Re-establishing access to care is a necessary response to the effects of the crisis; it is also an essential part of how, beyond the health sector, society can find a way out of the social, economic and political crises it finds itself in.

C. Recovery and reform

At the same time, there is a need for ambitious structural investment in relief and recovery that supports a realistic and sustainable budgetary framework. Such investment is needed to remedy the harm caused to the people's health and to the health system by the concatenation of crises. It is also needed to protect and sustain such pre-crisis achievements as strides made in controlling the cost and availability of pharmaceuticals, or in using accreditation for quality improvement. Importantly, investment must be accompanied by the reforms necessary to correct the pre-existing systemic distortions that are responsible for inefficiencies and inequities, such as supply-induced demand,

or the systemic disincentives in prevention and promotion of health and well-being. Recovery is an opportunity to build a stronger and more resilient system that responds better to the needs and expectations of the population.

2. Vision 2030

Vision 2030 sets out the National Health Strategy for investing in relief and recovery. It addresses the challenge of leading the health system from its current state of burnout on to a course of sustainable recovery, modernization and structural reform. It envisions Lebanon will become:

- A country where communities, families and individuals live healthier lives and enjoy access to better quality care.
- A country where public as well as private health care providers work together to protect and improve the people's health, by addressing the key determinants of health and organizing universal health coverage.
- A country where health authorities are trusted to work in the public interest, free from capture by special interests and committed to leaving no one behind.

The mission of Vision 2030 is to galvanise authorities and key forces in Lebanese society in an effort to recover the health sector from the current crises, and to conduct the necessary reforms to the way the health sector is organized and operates. It relies on the leadership of the Ministry and its allies to:

- Sustain strategic networks and partnerships of sector stakeholders around shared agendas serving the public interest.
- Identify priority strategic interventions and mobilize the required resources for a paradigm shift in the governance and organization of the delivery of services and the protection of health and well-being.
- Build the capacity for anticipating upcoming challenges and for designing and implementing effective, efficient and equitable responses to the legitimate expectations of communities, families and individuals.

Vision 2030 lays out four areas for strategic investment in the recovery of the health sector. In each area, the stakeholders of the health sector must join forces to respond with rapid relief to the health effects of the crisis and rebuild a sustainable and resilient health system. Jointly, they can respond to the escalation of unmet health needs, while participating in defining the direction of recovery and reform. These strategic areas are:

- *Expanded universal health coverage:* addressing key structural problems – access, quality, sustainability, resourcing – to foster equitable access to improved care.
- *Healthier living*: health promotion and disease prevention, with relevant action on determinants of health.
- *Health governance in the public interest:* stepping up systematic efforts to build trust and align government and non-government resources with national goals and the public interest, with special focus on digitalization of the health system to improve transparency and accountability, and reinforcing the regulatory capacity of the Ministry of Public Health.
- *Health security:* enhancing health emergency preparedness, readiness and response, fostering intersectoral partnership using the One Health approach within the overall international health regulations.

3. The health sector of Lebanon in the years of crisis

A. The pre-crisis track record: better health and improved efficiency

Health outcomes in Lebanon improved considerably since the beginning of the century, and there were notable advances in health system efficiency. Life expectancy increased to 79 years, 11 years more than the regional average and 5 years above that of the world's middle-income countries. One of the few countries in the world to achieve the fourth and fifth Millennium Development Goals, Lebanon reduced infant mortality from 31 to 7 and maternal mortality from 104 to 16 per 100,000 live births (among the fastest reductions worldwide). The country ranked in the world's top quartile for a number of comparative health outcomes indexes, such as those of *The Economist* or Bloomberg. It scored thirty-first out of 195 countries for the Health Care Access and Quality index. Though it relied mainly on donor support in emergency preparedness, Lebanon was able to muster one of the most efficient responses to the COVID-19 pandemic in the region. The activist and information-driven efforts of the Ministry and its allies played an important role in obtaining these results. The Ministry set up a primary health care network in partnership with NGOs and municipalities and negotiated the autonomy and accreditation of hospitals. It modernized public purchasing of care with value-based contracting, an electronic visa system and a unified database of beneficiaries. Its investments in the supply chain of pharmaceuticals and medical products brought down the out-of-pocket cost of medicines significantly. However, towards the 2020s incremental progress ground to a halt.

B. A concatenation of crises

The advances of the 2000s and 2010s were obtained in spite of a decidedly difficult socioeconomic context. Lebanon has experienced decades of geopolitical volatility, with long periods of government paralysis and insecurity. As the 2020s approached, however, a succession of overlapping emergencies now piled up into a perfect storm that constitutes the worst and most complex crisis in the country's history. In 2006, military action destabilized the country and led to severe infrastructure damage. As of 2011, the influx of Syrian refugees added to the country's social and economic burden. In 2019, the lingering fiscal and financial crisis escalated rapidly, with a 90 per cent devaluation of the local currency and restrictions on the use of foreign currency. The COVID-19 pandemic further aggravated the country's fragile situation, while the Beirut port explosion destroyed a large part of the city, affecting more than 300,000 people. A fuel crisis interfered with all aspects of daily life. The GDP dropped from $55 billion in 2018 to $33 billion in 2020, with the GDP per capita falling by around 40 per cent. The minimum wage is worth about $1 per day. Annual inflation is above 200 per cent. Many Lebanese have left – and a 2022 poll by Arab Barometer found that 48 per cent of Lebanese, and 63 per cent of young Lebanese, want to emigrate. The World Bank estimates that around 75 per cent of the Lebanese population and more than 95 per cent of the Syrian refugees are now below the poverty line.

C. Health gains under threat

These interlocking crises now threaten to reverse the health gains of the past twenty years, as well as the viability and performance of the health system.

Living conditions are deteriorating fast: socially, psychologically and physically. Environmental degradation is accelerating. The waste management crisis has become chronic. Reliance on diesel generators to make up for the faltering electricity supply contributes to poor quality of air and high levels of pollution, with associated emergency admissions for asthma and exacerbations of chronic obstructive pulmonary disease. Tapwater seldom runs, in one

out of two households it is contaminated and the frequency of waterborne disease outbreaks is rising. The major threat to health derives from the runaway proliferation of poverty. Three out of four Lebanese are now classified as poor. Forty per cent of households (and counting) report challenges in accessing food and other basic needs. With unemployment above 50 per cent, less than 30 per cent of the population benefits from (limited) social or health insurance protection. Life is harder now and farther from what people were led to expect – in particular, but by no means only, for the poorest and most vulnerable. That this affects health outcomes became plainly visible in the early 2020s. Reversals of previous gains are now beginning to show up in critical indicators, such as, for example, rising neonatal and maternal mortality rates. The incidence of mental health problems is rising, with a quadrupling between 2019 and 2021 in requests for support by people with suicidal ideation. Non-COVID-19 excess mortality in 2020 was 3.4 per cent.

D. Declining service uptake

Until the mid-2020s the health system managed to cope with the challenges of crises and impoverishment. Towards the end of the second decade, however, the accumulation of political deadlock, fiscal crisis, economic meltdown, social instability and collapsing infrastructure brought the health system to its knees. The breakdown was most evident in the spectacular fall in access to and uptake of health care services. Hospital admissions declined by 20 per cent in 2020, with a 10 per cent decline for neoplasms. This trend accelerated to a further 28 per cent decline in admissions, with a 48 per cent decline for neoplasms, in 2021. Inadequate care for the 8,000–10,000 yearly new cases of cancer will definitely extract a toll in adverse outcomes. Vaccination from public providers declined by at least 30 per cent, and by 40 per cent from the private sector; the overall drop is set to exceed 50 per cent. In the meantime, the number of users of the Ministry primary health care network, which targets the poor and vulnerable, doubled between 2019 and 2021. Its non-communicable disease medication programme steadily increased its clientele, with a 10 per cent annual growth in beneficiaries. This constitutes a shift of patients away from private ambulatory care that has become unaffordable.

The conjunction of increased need and declining service uptake is the result of demand- as well as supply-side factors.

E. Inability to pay and self-rationing

Impoverishment and inability to pay constitute real barriers to access care, which are insurmountable for many households. Out-of-pocket payments for health care have been cripplingly high in past years too: they reached 60 per cent of total health expenditure in the 1990s. A number of policy interventions then led to a significant reduction, but they still constituted one third of total health expenditure in the 2010s. Currently, however, many Lebanese simply no longer have the resources to pay for health care. The speed of this deterioration is arresting: in just six months, the share of households having difficulty accessing health care rose from 25 per cent (July–August 2020) to 36 per cent (November–-December 2020). There is no doubt that inability to pay makes people look for more affordable sources of care than those they used to frequent, or forgo them altogether.

F. Shrinking workforce

Yet inability to pay is not the only constraint households face in looking for care. The offer of services itself has shrivelled. Before the crisis, medical density, the number of medical doctors per inhabitant, was the same as the European average. Since the crisis began, the country has lost 40 per cent of its doctors to emigration (along with 20

per cent of nurses, a category that struggled to maintain adequate human resources even before the crisis). Health workers have seen the purchasing power of their pay check divided by 12; those on fee-for-service income have to rely on a reduced client base with diminished ability to pay. In a system used to a comfortable supply of human resources, this sudden and massive reduction in the offer of services comes with cutbacks on timeliness and quality of care, and a sudden need to adapt its organization to a new reality of scarcity.

G. Disrupted activities

On top of that, the ordinary daily work of hospitals, clinics and health centres is hindered by bottlenecks, such as lack of fuel and electricity, increasing obsolescence of the telecom infrastructure and the impossibility of obtaining foreign currency to purchase supplies. Most hospitals are currently operating at 50 per cent capacity, prioritizing life-saving interventions while some patients may be refused admission. Private ambulatory care has been scaled down, and health centres have to face an expanding clientele with reduced means, rationing fuel consumption by reducing opening hours. Many service points see their continued existence threatened by insolvency. For patients, it means that services have become not only more difficult to afford, but also more difficult to obtain.

H. Shortage of medicines

Even before the crisis, medicines made up 54 per cent of out-of-pocket health expenditure; the pharmaceutical sector had a market size of some $1.2 billion per year. More than 90 per cent of pharmaceuticals and all medical supplies and equipment are imports. In 2020, government subsidies were scrapped and access to foreign exchange was restricted. Imports of pharmaceuticals fell by 60 per cent, and of medical supplies by 80 per cent. More than 600 of the 4,000 private pharmacies closed. The country has experienced a series of episodes of shortage, including of essential medicines. This has been a cause of widespread anxiety, and led to hoarding and rationing of the dispensing market through pharmacies. There have also been direct health consequences, with reports of emergency room admissions for emergencies caused by lack of diuretics, anti-epileptics, blood thinners, insulin or antibiotics. The Ministry has used donor funds to safeguard access to critical non-communicable disease medications and vaccines through the primary health care network, and to medications for cancer and catastrophic illness through the central drug warehouse. This, however, represents less than 10 per cent of the total pharmaceutical market in the country.

I. The mismatch between needs, expectations and benefits

This breakdown of normal operations has exacerbated pre-existing gaps and distortions. The Lebanese health care landscape has been shaped by the post-war proliferation, largely unplanned and hardly regulated, of a multitude of private health entrepreneurs, commercial as well as not-for-profit. These have nurtured a culture of supply-induced demand for sophisticated, high-tech, subspecialist care. Political pressure has sustained this trend by directing funds towards tertiary care, ad hoc discretionary interventions and measures to protect the interests of allied providers. Among citizens, this has entrenched unrealistic and unsustainable expectations as to what the public purse should support. The losing parties have been less glamorous, but critical, services: quality primary care, prevention and promotion, mental health, palliative care and emergency preparedness. These remained underfunded by authorities, overlooked by professionals and disdained by the public.

The upshot is that with the sudden impoverishment affecting the entire society, people now not only have lost access to the sophisticated care they have grown to expect, but also to the basic, minimal care required to cover

their objective needs. Power to purchase desired health commodities has dwindled, yet unrealistic expectations for access to high-tech care persist. In the Lebanese context, the disconnect between the health benefits the system can offer, the unmet needs and the unmet expectations, is nothing new. Now, that disconnect adds to widespread dissatisfaction and distrust. It delegitimizes the public service discourse of health authorities. This is gearing up as a major political challenge, as much as a technical one, for the negotiation of benefits packages in the recovery from the crisis.

J. A regulatory portfolio grinds to a halt

In the years leading up to the current crisis, the Ministry of Public Health emerged as the key regulatory institution. It was the driver of initiatives that infused the sector with a sense of purpose and a concern with equity. Its regulatory capacity improved over time, within the limits imposed by political volatility and lack of budgetary visibility. Key in building governance authority was the smart and nimble use of strategic intelligence and reliable, factual information. This allowed the Ministry to constitute a portfolio of technical reforms and make effective use of its financial leverage. As purchaser of 30 per cent of the country's volume of hospital care, and with a key role in the circuit of expensive and life-saving medicines, the Ministry used its financial leverage to rationalize the purchase of hospital care. For ambulatory care, it did not have the means to deploy financial incentives and disincentives, as much of the service offer remained unregulated. But in the primary health care network run by NGOs and municipalities, the Ministry and its allies did manage to rationalize packages of ambulatory care benefits. Bit by bit, a portfolio of regulatory activities was constituted, which included the autonomy of public hospitals, quality improvement through accreditation and contracting incentives, utilization of review, third-party administration, value-based hospital contracting, automated DHIS2 surveillance and barcoding of medicines.

The crises have put the brakes on these efforts. Legislative initiatives – on universal health coverage, tobacco taxation and international health regulations, among others – are frozen in the parliament. Initiatives on drug substitution, electronic medical prescription and tracking of barcoded medicines appear to have slowed down. The consultative committees that bring together public, private and academic expertise to support decisions on infectious diseases, EPI, cancer or licensing of medications are not meeting regularly (if at all). Of particular concern is the lack of progress with the electronic medical records. Without an electronic medical record, it is not possible to transform current ambulatory care into the modern people-centred care required to respond to health needs and have legitimate expectations for respectful and humanized care.

K. Health governance in need of a reset

The paralysis of policy innovation jeopardizes quality of care and the management of universal health coverage. There is need for a reset of active governance of the sector: setting the policy direction, making sure concerns for equity have their rightful place and expanding a relevant regulatory portfolio to safeguard the interests of the public. The capital of past regulatory strengths is still considerable, yet there are a number of critical vulnerabilities that must be addressed.

People and politics

The crisis is rapidly depleting the capital of people to conduct the business of governing the health sector. Over the past years, dedicated and competent teams have been assembled, within the Ministry and among its network of allies. These were the people with the institutional memory and the operational knowledge that is indispensable for

effective sector governance. In the current breakdown, some 30 per cent of that staff has quit. Even making the context of the crisis and the loss of capacities abstract, replacing staff is blocked by a law that prohibits recruitment by public institutions. Moreover, it is weakened by an obsolete organigram, which, for example, does not provide for a unit to deal with epidemiologic surveillance. The remaining staff have had to cut down their output as the crisis disrupts day-to-day activities and reduces operating funds. They continue to be exposed to political interference, as the discretionary power of ministers and political appointees in the health sector biases work towards short-term political considerations. This introduces an ongoing element of fragility and instability in regulatory initiatives and budget allocations. The governance of public hospitals, where confessional and political power sharing arrangements trump technical and managerial considerations, is particularly vulnerable.

Siloed funding streams and unaligned benefit packages

A second vulnerability is the persistence of silos in purchasing health care, along the funding streams managed by the Ministry, the National Social Security Fund, the Civil Servants' Cooperative, military schemes and private insurance. These silos segment the population according to the funding stream. The fragmentation of financing is not as such the problem – it has at times even offered welcome tactical flexibility – but it does mean that the package of benefits differs for each population segment.
Different purchasers negotiate separate arrangements with the providers of their constituents. These arrangements may include unsustainable components and often rely heavily on fee-for-service payments against itemized bills. The way each purchaser uses – or fails to use – its financial leverage for more sound priority setting, improved equity or better quality of care varies considerably from one to the other. This has siloed the design and regulation of benefits packages for different population segments. In terms of population outcomes and health system efficiency, this not only translates to inequalities, but also to missed opportunities to get value for money. Each purchaser has in the past resisted the harmonization of their benefits packages and negotiation strategies. As a result, they have failed to pool information, combine their leverage and strengthen their common negotiation position vis-à-vis providers.

The situation of the different purchasing agencies is shifting fast. First, in the current monetary context their purchasing power has suffered an 80–90 per cent cut, while their sources of funding, particularly of government revenue and social security contributions, are drying up. Second, rising unemployment implies a reconfiguration of their constituencies, with a shift from the social security segment to that covered by the Ministry as the insurer of last resort (the Ministry segment is expected to grow from 48–52 per cent of the population to 70–75 per cent). Third, the governance of the health sector is becoming ever more complex. Fragile purchasing agencies intersect with new prepayment and community insurance initiatives. The number and weight of donor-funded projects multiplies, with the agendas of external technical agencies newly prominent. All this adds to the political complexity of sector governance and the multiplicity of decision-making centres. The unpredictability of the budgetary space – a chronic source of destabilization of the management of public funds in pre-crisis years – is likely to get worse before it gets better. It will require solutions for the debts of the past and political commitment for the legal and organizational challenge of unifying funding streams and negotiating benefits packages.

Strategic intelligence

The production of strategic intelligence used to be a critical source of strength in guiding policy formation and system management in Lebanon. In the current disarray, this critical activity has ground to a halt. This is leading to loss of institutional memory and a growing obsolescence of information gathered at great cost in the period before

the crisis. One example is that of the national health accounts. The information provided by the 2017 NHA can hardly serve as a detailed guide for decision-making in the current context. The same is true for a whole range of other issues: the distribution of human resources, the trends in out-of-pocket expenditure, the performance of health care providers, funding flows, the epidemiological situation, unmet needs and so on. Importantly, brain drain, both from the Ministry and from academia, risks curtailing the capacity to prioritize, design and launch the surveys and studies necessary to guide recovery.

L. Recovery will take time

The health system in Lebanon presented structural fault lines and distortions that could not withstand the concatenation of crises of the past few years. The damage done is considerable. Things may get worse before they get better, depending on the speed of mobilizing the resources for emergency relief and response, structural recovery and reform. Many households will have to rely on out-of-pocket spending for quite a while. The government capacity to subsidize the health of the poor and vulnerable is limited and will be dependent on donor funding to a degree that requires new mechanisms to ensure country ownership and alignment to national priorities. Uncritical satisfaction of unrealistic expectations for public subsidy to low-impact, high-tech care will prove unfeasible in the financial context of the coming years. Paradoxically, this increases the leverage of the Ministry and its governance allies to revisit contractual arrangements with hospitals, rationalize ambulatory care and expand public initiatives to hereto underinvested public health functions. This calls for a time frame of ten to fifteen years, with substantial new fiscal space for investing in the recovery and reform of the health sector.

M. Four areas for strategic investment in sector recovery

The four strategic areas for investment in sector recovery are:

- *Expanded universal health coverage:* addressing key structural problems – access, quality, sustainability, resourcing – to foster equitable access to improved care.
- *Healthier living*: health promotion and disease prevention, with relevant action on determinants of health, and modifiable risk factors.
- *Health governance in the public interest:* stepping up systematic efforts to build trust and align government and non-government resources with national goals and the public interest, with special focus on digitalization of the health system to improve transparency and accountability, and reinforcing Ministry of Public Health regulatory capacity. Consider having all public funds under one autonomous health authority with a well-defined governance structure.
- *Health security:* enhancing health emergency preparedness, readiness and response, fostering intersectoral partnerships using the One Health approach within the overall international health regulations.

Emergency project funding for crisis response and relief should be aligned to these four areas for investment, with a focus on re-establishing access to care. Towards the medium term, support should move along structural support of a realistic and sustainable budgetary framework for the country.

These four areas map to the Strategic Directions and Objectives document, respectively: SD 2 (Harmonized financing and benefit packages), SD 3 (transform service delivery), and SD 1.3; SD 1 (Health promotion and disease prevention) and SD 4.3–5 (Ministry capacities); and SD 4.1–2 (capacity for leadership) and SD5 (resilience and adaptability).

N. Strategic Investment, area 1: Expanding universal health coverage: Equitable access to better care

Expanding universal health coverage remains the core strategy for the recovery – for both health and social reasons. Universal health coverage is access for all to timely, quality, people-centred care, with the necessary arrangements to avoid exposing users to financial hardship.

The transformative lines of action for expanding universal health coverage are (a) redefining a health benefits package that makes equitable access realistic; and (b) redesigning service provision to allow for a better quality and more satisfactory patient experience.

These need to be supported by (c) investment in the sector's human resources and (d) capitalization on and expansion of the achievements in ensuring affordable access to pharmaceuticals and technology.

1.1: Establish a Health Benefits Package Task Force

The Health Benefits Package Task Force will be charged with overseeing the design, adoption and roll-out of access to a unified health benefits package. The remit of the Health Benefits Package Task Force is to:

- Set up the processes and structures to define a unified, collectively financed health benefits package. This package pertains to hospital as well as ambulatory care benefits and should satisfy the following criteria:
  - Starting from a limited "crisis" range that can be provided to the poor and vulnerable as an immediate response to the ongoing crisis situation, it is designed to expand as fiscal space expands when the country emerges from the crisis.
  - It is designed to be clear and intelligible for all potential users.
  - It is developed considering evidence on needs, effectiveness and financial sustainability.
  - It enjoys social consensus, as a result of being designed in a process that is transparent, by trusted and respected authorities, and through processes that are visibly protected against capture by special interests.
- Set up a process for general adoption of the health benefits package, and organize the negotiation of:
  - Adoption of the package as guaranteed to all beneficiaries of all public funds and users of Ministry services.
  - Harmonization of the financial and technical management processes of the different funds, as a prelude to unification under a single autonomous purchasing authority.
  - Refocusing of private insurance funds and mutuality funds towards progressive adoption of the health benefits package as a mandatory minimum for all adherents, albeit with the possibility of regulated complementary benefits.

1.2: Transition to value-based and people-centred services

Investment is necessary to transition from the current transactional and provider-centred service models to value-based and people-centred service delivery. The work of the Health Benefits Package Task Force will be key here, so that unification of the health benefits package can serve as the basis for unifying purchaser leverage in the negotiations with providers and for defining the legal frameworks for the public purchase of quality-assured care.

- *Ambulatory care* has remained largely transactional and unregulated – with the exception of the facilities in the primary health care network, where contractual arrangements provide the Ministry with a minimal degree of oversight and leverage. This situation can change with the generalization of a publicly funded health benefits

package, and regulated gatekeeping for access to specialist care and diagnostics. Methods of active engagement of the private sector in primary care delivery, such as a network of accredited family doctors and trained general practitioners in the catchment area of their private practice, along with private diagnostic centres and pharmacies, or outpatient departments in public and private hospitals, need to be explored and piloted. In addition, they will contribute to disease surveillance. Participation in these mechanisms will rapidly become a de facto necessity for establishing a sustainable client base. This in turn will provide purchasers with new regulatory leverage over private ambulatory care. Public purchasers will be able to make use of payment incentives and accreditation mechanisms to promote key attributes of good primary care, including registration, systematic use of standardized electronic medical records, acquisition of primary care level skills, case management and continuity of care and compliance with evidence-based medicine recommendations.

- *Hospitals* have been severely affected by the crisis, which has transformed the whole landscape. This makes it necessary to review the whole configuration of the distribution of hospitals, major technology and emergency medical services. This review should be done in the form of three related master plans (hospitals, technology and emergency medical services), based on long-term scenarios to guide consolidation, specialization and complementarity between private and public hospitals. The planning process, led by the Ministry and with involvement of all relevant stakeholders, will be guided by three principles: a focus on frontline, “close to client” public hospitals (hôpitaux de proximité); progressive care as a planning principle; and reinforcement of the accreditation and rationalized purchasing approaches developed in the 2010s.

1.3: Human resources for health

Investment in human resources is necessary to adapt to and compensate for the sudden scarcity of human resources. The priority is to support quality, people-centred ambulatory care by setting up the studies and systems to provide strategic intelligence to policymakers, including on solvency, migration and factors determining retention (career perspectives and perceptions, economic conditions, burnout, social recognition, staff morale and professional satisfaction). This has to guide investment in production, retention and repurposing of medical, nursing and ancillary staff for the modern world of primary care and family medicine. International collaboration and exchange will be sought to develop programmes that take full advantage of recent organizational, clinical and digital developments in continuous learning in support of primary care.

1.4: Safeguarding and expanding the Ministry medical products and supplies portfolio

In the past decade, the Ministry has made important investments in systems to register, quality control, track and contain the cost of medicines, implants and supplies. These have in the past significantly contributed to rationalizing access and reducing or containing household out-of-pocket expenditures. The crisis has constrained the whole supply chain to an extent that the systems that have been put in place are now at risk. Necessary fresh funding will have to ensure that they are revived and enhanced.

The strategic pillars for doing so have been agreed upon in 2022. They comprise: (a) securing universal and sustainable access to quality and safe medications, including generics; (b) ensuring early access to innovative medications while maintaining resource optimisation; (c) optimizing expansion and supporting local industry by increasing its production capacities for local and export markets; (d) optimizing human resources in the pharmaceutical sector through retention and education strategies; (e) activating the role of patient associations in decision-making; (f) promoting the rational use of medications by prescribers, dispensers and consumers; (g)

digitalizing the system using 2D barcodes, MediTrack, health technology assessments and electronic medical cards; (h) implementing the Lebanese Drug Administration to strengthen the regulatory process.

O. Strategic Investment, area 2: Healthier living: Health promotion and disease prevention

Healthier Living invests in an answer to one of the major paradoxes of the Lebanese health system: a sophisticated curative care infrastructure alongside a relative neglect of risk reduction, disease prevention and healthy lifestyles. To correct this paradox, sector stakeholders are to develop programmes and initiatives targeting four priorities:

2.1 Intervene at the policy, prevention/screening and management levels to reduce high-impact health risks (smoking, unhealthy diet, environmental pollution, traffic, occupational health, among other) with a systematic programme of mapping and monitoring; building awareness among authorities, health professionals and communities; and leveraging legal and regulatory measures. In addition, there should be a set of initiatives to improve health literacy by increasing awareness and promoting healthy lifestyles.

2.2 Monitor and promote population health through priority programmes such as those for non-communicable diseases (including cardiovascular problems, cancer and mental health), nutrition (breastfeeding, malnutrition screening), mother, adolescent and child health (sexual and reproductive health, women's health, youth health risk behaviours). This can be done by the establishment of selected registries and surveillance systems in partnership with communities of practice and professional orders, among others.

P. Strategic Investment, area 3: Health governance in the public interest: leadership, steering and regulating

Health governance in the public interest is intended to re-establish trust in health authorities and align government and non-government resources with national goals and the public interest. To this effect, the Ministry and other sector stakeholders are to develop programmes and initiatives to:

3.1. Make regulation and sector governance fact- and evidence-based, by agreeing on a shared agenda and implementation arrangements of studies and research to produce strategic intelligence and regulatory capacity. The agenda is to be designed to directly benefit the work of the Health Benefits Package Task Force on expanding universal health coverage. An immediate priority action point within that agenda is to set up the systems for identification of the poor and vulnerable. The agenda is to include the programming of the key surveys and studies, with particular attention paid to the sustainability of progress towards universal health coverage. The agenda is to serve as a critical input for the design of a national health information system master plan and for contributing to a learning environment of experimentation and innovation.

3.2. Institutionalize and sustain collaborative sector governance through involvement of key stakeholders – including civil society organizations – building on the pre-crisis experience of the Ministry with collaborative governance: bespoke arrangements tailored to the stakeholders and the type of collaboration pursued, including shared decision-making, establishment of provider networks, programme oversight and advice activities, policy dialogue on the implementation and adjustment of the recovery and reform strategies, and so on. It will require investment in the capacity and structures for sector leadership of the Ministry by capacity-building and modernizing the

organigram,with additional and essential new units needed, and continued close ,coordination with other key stakeholders.

3.3. Operationalize the One Health and Health in All Policies concepts. First, institutionalize intersectoral consultations and mechanisms aiming to ensure legitimate health concerns are prominent in the country's recovery plans, across the various sectors. This requires a government consensus on institutionalizing the commissioning of a systematic ex-ante assessment of the expected health impacts of the recovery plans and projects of the various sectors, as of their design phase. Second, plan and commission the production, collation and sharing across Government and among key stakeholders actionable information on the health impact of environmental challenges, with a focus on waste management, air pollution, non–health care sources of antimicrobial resistance and the consequences of global warming. Third, organize the participation of Lebanese human and veterinary public health authorities in regional zoonotic emergency prevention and intervention programmes.

Q. Strategic Investment, area 4: Emergency health preparedness response and recovery

Health security intends to pre-empt health emergencies and improve country readiness to face catastrophic health incidents and pandemics. Within the All-Hazards Approach, and in line with IHR, the Ministry and other sector stakeholders are to develop programmes and initiatives to:

4.1. Ensure emergency preparedness and response capacity. Develop high quality, regularly stress-tested and updated preparedness plans and structures with clear lines of command and control, and risk communication led by the Ministry. The preparedness plans are to be integrated with regional Mediterranean preparedness networks, and build on the experience with managing the COVID-19 pandemic. Key features include measures to ring-fence resources, including a functional central public health laboratory and an upgraded national ESU with timely surveillance and timely response.

4.2. Enhance the coordination capacity of the Ministry of Public Health. This includes establishing an emergency operation unit or team at the Ministry to coordinate health emergencies preparedness and response, develop plans for capacity-building and enhance multisectoral partnership.

4.3. Re-establish critical public health functions. These include the central public health lab, to be re-established through a network of national reference labs, antimicrobial surveillance and a national infection prevention and control programme, expanding the early warning alert and response system including indicator-based surveillance and event-based surveillance, through full automation and operationalization of the One Health approach.

R. Strategic Investment Area 5: Digitalization

A fifth strategic investment area could be designed to finance the development and implementation of an information management system master plan. This would be done in agreement with donors, based on this health sector strategy document, considering digitalization as a cross-cutting component and a cornerstone for all of the above investment areas.

An immediate agenda: The relief and recovery fund and council

Neither the immediate crisis relief and response nor the structural investment in recovery and reform can be expected to be financed exclusively from domestic public sources. Proper financing will have to be constructed from multiple sources and agencies, including by seeking international donations and/or soft loan support as a transition bridge to move from the ongoing humanitarian/emergency support to sustainable financing.

The Health Crisis Response and Recovery Fund

The operationalization of Vision 2030 requires the various agencies and stakeholders contributing to the Lebanese health sector to elaborate aligned resource and implementation plans. Resourcing – of emergency relief and response projects and of structural investment in a realistic and sustainable budgetary framework – should be brought together as a sector-wide Health Relief and Recovery Fund to be accountable to the Office of the Prime Minister. This is necessary to ensure multiple-source funding comes with implementation plans that are aligned to the country's strategic plan harmonized with its operational and fiscal frameworks, and accountable to public scrutiny. Negotiating the constitution of such a fund, with the commitments of the relevant agencies and stakeholders and their corresponding management structures, is a matter of urgency in order to transition from the emergency to the recovery phase. A similar fund was established in 2007 and operated through the United Nations after the July 2006 war. It could be reactivated, with an earmarked budget line for the health sector.

The Ministry has to take the initiative and the lead for mobilizing agencies and stakeholders to commit to Vision 2030, and for translating that commitment into budgetary commitments and operational plans, with clear and realistic milestones and targets for monitoring the progress with the reforms and investments.

The Health Crisis Response and Recovery Council

The multiplication of initiatives and inputs to provide relief and support recovery add to the complexity of governing the health sector. Singular inputs may insufficiently fit within the National Health Strategy, or be biased by conflicting institutional agendas: this calls for active efforts to align contributions early on from the design and negotiation stage. The financial and technical implementation arrangements may require harmonization to avoid inefficiencies, redundancies and conflicting planning and implementation cycles. Mobilizing the resources and efforts of multiple agencies and stakeholders constitutes a considerable challenge for health authorities. This requires mechanisms and structures that bring together the agencies and stakeholders to:

- Ensure synergies or at the very least avoid gaps and duplication.
- Guarantee alignment and harmonization of all contributions.
- Safeguard national ownership and primacy of the public interest in all contributions.
- Attest to the realism of the plans and the plausibility of the costing information.

The umbrella structure to do so is a national Health Crisis Response and Recovery Council, nominated through the Cabinet of the Prime Minister. Under Ministry leadership, the Council would bring together the major agencies, both internal and external, that are active players in the health sector, as funders and/or implementers. The Council itself should not serve as an implementing agency, but as locus of oversight of the fund, and as the forum for broadening policy dialogue to develop coherent sector policies. It should address private as well as public sector issues, with commonly agreed realistic expenditure programmes and monitoring arrangements. It would do so with a formal, legal, five-year mandate that ring-fences it from day-to-day political interference. Its remit would include:

- Mobilizing and coordinating inputs and roles.
- Supporting the implementation plans of the various stakeholders.
- Monitoring and ensuring alignment and harmonization.
- Ensuring proper processes and structures are in place (including for communication with civil society).
- Monitoring progress with recovery, with adequate control and audit mechanisms.
- Adapting the recovery strategy and the related action plans to the evolving situation.

Establishing the Fund and its oversight Council structure prefigures the pooled funding–based universal health coverage system that needs to be rolled out over the coming decade. It allows for ongoing selection of funding options and for building the mechanisms and trust for accountable governance.

Preparatory steps

Immediate preparatory steps for the establishment of the Fund and the Council include:

- Mapping all ongoing or planned initiatives (projects, funding and activities within the next three to five years) and potential sources of funding of relevance to the sector.
- Listing the agencies and stakeholders whose participation in the council is strategic.
- The negotiation of the terms of reference for the Fund and the Council.